TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EAST TEXAS INFECTIOUS DISEASE

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-15-3127-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the scattered payment pattern on the above patient's claims. Per attached EOB for above dates of service, Gallagher Bassett paid for only 3 days of service for A4305. Why A4305 was not paid for remainder of claim. On prior claim, J2543 was paid in the amount of $23.28 for each date of service, and S9502 was paid at $100.00 per daily charge. Why these were not paid on these dates of service. Gallagher Bassett EOB's are attached. I have also attached letter of 3/9/2015 requesting payment."

Amount in Dispute: $1,284.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of all received documentation, additional allowance is being recommended. Adjustments are in progress for DOS 7/23/2014 – 7/26//2014 and 7/24/2014 – 7/29/2014."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2014 July 24, 2014 July 25, 2014 July 26, 2014 July 27, 2014 July 28, 2014 July 29, 2014	HCPCS Code J2543-GR Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	$23.28/ea	$0.00
July 23, 2014 July 24, 2014 July 25, 2014 July 26, 2014	HCPCS Code A4305 Disposable drug delivery system, flow rate of 50 ml or greater per hour	$108.00/ea	$0.00
July 24, 2014 July 25, 2014 July 26, 2014 July 27, 2014 July 28, 2014 July 29, 2014	HCPCS Code S9502 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	$100.00/ea	$0.00
TOTAL		$1,284.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. Neither party to this dispute submitted any copies of explanation of benefits to support basis of this dispute.

Issues

1. Did the respondent submit documentation to support position that additional reimbursement was made for the disputed services?
2. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?
3. Does the documentation support billing HCPCS codes J2543-GR, A4305 and S9502? Is the requestor entitled to reimbursement?

Findings

1. The respondent states in position summary that "After review of all received documentation, additional allowance is being recommended." No documentation was submitted to support an additional allowance was made; therefore, this decision is based upon the submitted documentation.
2. 28 Texas Administrative Code §133.307(c)(2)(K) states "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." A review of the submitted documentation finds that the requestor did not submit any EOBs for the disputed services nor convincing documentation providing evidence of insurance carrier receipt of the request for an EOB.

   28 Texas Administrative Code §133.307(c)(2)(M) states "a copy of all applicable medical records related to the dates of service in dispute." A review of the submitted documentation finds that the requestor did not submit any copies of medical records to support disputed services.

   The Division concludes that the request for medical fee dispute resolution was not filed in the form and manner required by 28 Texas Administrative Code §133.307(c)(2)(K) and (M).
3. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The requestor did not submit any medical records to support reporting and billing HCPCS codes J2543-GR, A4305 and S9502. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		08/19/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.